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No.

In the Supreme Court of the United States

OCTOBER TERM, 1984

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL., PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED

Whether the district court had jurisdiction under 28 U.S.C. 1331 to entertain respondents' challenge to a regulation affecting the amount of benefits payable for medical services under Part B of the Medicare Program, notwithstanding the preclusion of review in 42 U.S.C. 405(h) and 1395ff.

PARTIES TO THE PROCEEDING

The petitioners are Margaret M. Heckler, Secretary of Health and Human Services, and Blue Cross and Blue Shield of Michigan, an insurance carrier that has contracted with the Secretary pursuant to 42 U.S.C. (& Supp. V) 1395u to administer the Part B Medicare Program in Michigan on her behalf.

The respondents are: (1) the Michigan Academy of Family Physicians, a non-profit association of family physicians in Michigan; (2) Lester Webb and Charles Farber, family physicians who are eligible for specialist certification under the standards of the American Board of Family Practice but who have not been certified by the Board; (3) Glenn House, a family physician certified as a specialist under the standards of the American Board of Family Practice; and (4) Carol A. Diedrich, a resident of Michigan and a Medicare Part B recipient whose treating physician, Philip Lang, is a family physician who is neither board-certified nor Board-eligible.

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v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Solicitor General, on behalf of the Secretary of Health and Human Services and Blue Cross and Blue Shield of Michigan, an insurance carrier that administers the payment of claims under the Part B Medicare Program on behalf of the Secretary, petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-13a) is reported at 728 F.2d 326. The opinion of the district court (App., *infra*, 15a-23a) is reported at 502 F. Supp. 751.

JURISDICTION

The judgment of the court of appeals was entered on February 23, 1984 (App., *infra*, 14a). By order dated May 15, 1984, Justice O'Connor extended the time within which to file a petition for a writ of certiorari to and including July 22, 1984. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY PROVISIONS AND REGULATION INVOLVED

28 U.S.C. 1331 and 1361; relevant provisions of the Social Security Act, 42 U.S.C. 1395a, 1395ff(a) and (b), 42 U.S.C. (& Supp. V) 1395u(b)(3); and 42 C.F.R. 405.504(b) are reproduced at App., *infra*, 24a-26a.

STATEMENT

This case concerns the jurisdiction of a federal district court to entertain a challenge to a regulation affecting the amount of benefits to be paid for physicians' services under Part B of the Medicare Program.

1.a. The Medicare Program is divided into two parts. Part A (42 U.S.C. (& Supp. V) 1395c *et seq.*) provides insurance for the reasonable cost of hospital and related post-hospital services. 42 U.S.C. (& Supp. V) 1395c; 1395d. Part B (42 U.S.C. (& Supp. V) 1395j *et seq.*), at issue here, establishes a voluntary program of supplementary medical insurance covering, in general, 80% of the "reasonable charge" for physicians' and other medical services. 42 U.S.C. (& Supp. V) 1395k, 1395*l*, 1395x(s).

Under 42 U.S.C. (& Supp. V) 1395u, the Secretary of Health and Human Services is authorized to enter into contracts with private insurance carriers to administer the payment of Part B claims on behalf of the Secretary. *Schweiker* v. *McClure*, 456 U.S. 188, 190 (1982). Under these contracts, the carriers determine whether particular services are covered by Part B and the amount of the "reasonable charge" for such services. These determinations are made in accordance with regulations issued by the Secretary, through the Health Care Financing Administration (HCFA) in the Department of Health and Human Services. 42 C.F.R. 405.502(d). The Secretary is expressly authorized to issue such rules and regulations and to establish procedures to carry out the provisions of the Medicare Program. 42 U.S.C. 1395hh; 42 U.S.C. 405(a), as made applicable to the Medicare Program by 42 U.S.C. 1395ii. See *Heckler* v. *Campbell*, No. 81-1983 (May 16, 1983), slip op. 7-8.

A request for payment of services may be submitted by a Part B enrollee or by the physician or other person who rendered the services if the enrollee has assigned the claim to that person. 42 U.S.C. 1395u(b)(3)(B)(ii); *United States*

v. *Erika, Inc.*, 456 U.S. 201, 203, 207 n.7 (1982). If the carrier finds that the services are not covered by Part B or determines that the payment due is less than the amount claimed, the beneficiary or his assignee is entitled to have the claim reconsidered by the carrier. 42 C.F.R. 405.807-405.812. If the claim again is denied and the amount remaining in controversy is $100 or more, the claimant is entitled to an oral evidentiary hearing conducted by the carrier. 42 U.S.C. 1395u(b)(3)(C); see *Schweiker* v. *McClure*, 456 U.S. at 191.

Under 42 U.S.C. 1395ff(b)(1)(C) and (2), an individual is entitled to judicial review of the "amount of benefits under part A" of the Medicare Program if the amount in controversy after completion of administrative review is $1,000 or more. There is, however, no comparable provision in 42 U.S.C. 1395ff for judicial review of the "amount of benefits" determined to be payable on a claim under Part B of the Medicare Program. In *United States* v. *Erika, Inc.*, 456 U.S. at 206-211, this Court held that the text and legislative history of 42 U.S.C. 1395ff established that Congress "deliberately intended to foreclose further review of such claims" (456 U.S. at 208). Accord, *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984), slip op. 5 n.4.

b. The Social Security Act requires the carriers that administer the Part B program on the Secretary's behalf to make payment for covered services on the basis of a "reasonable charge" for the services. 42 U.S.C. 1395u(b)(3)(B). In determining the reasonable charge, the carrier is to "take into consideration the customary charges for similar services generally made by the physician * * * as well as the prevailing charges in the locality for similar services." 42 U.S.C. (& Supp. V) 1395u(b)(3). The Act further provides that the reasonable charge may not exceed the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75% of the customary charges made for similar services in the same locality during the preceding year (*ibid.*). Applying these principles, the reasonable charge for a physician's services ordinarily is the lowest of (1) the actual charge in the particular instance, (2) the physician's customary charge, and (3) the prevailing charge in the locality (App., *infra*, 2a). See 42 C.F.R. 405.502.

The regulation at issue in this case recognizes, however, that "[t]he range of prevailing charges in a locality may be different for physicians * * * who engage in a specialty practice or service than for others." 42 C.F.R. 405.504(b). It accordingly permits (but does not require) a carrier, based on "[e]xisting differentials in the level of charges between different kinds of practice or service," to develop more than one range of prevailing charges to be used by the carrier in determining the reasonable charge.

In 1968, pursuant to the regulation just discussed, Blue Cross/Blue Shield of Michigan (BC/BSM), the carrier responsible for administering the Part B program in Michigan, conducted a statistical analysis of physicians' charges in that State. Based on its analysis, BC/BSM identified three categories of physicians for purposes of developing "screens" to review requests for payment. The three categories were comprised of: (1) hospital internists and other hospital specialists, (2) other specialists, and (3) general practitioners and other non-specialists. The prevailing charges for specialists in Michigan were higher than those for non-specialists. Therefore, a Part B enrollee could receive a greater reimbursement under Medicare when he was treated by a specialist than when he was treated by a non-specialist. App., *infra*, 3a-4a.

After the Act was amended in 1972 to include chiropractors, podiatrists, and dentists within the definition of the term "physician" (42 U.S.C. 1395x(r)), those individuals were included in the non-specialist category (App., *infra*, 3a). Following creation of the family practice specialty, BC/BSM in 1973 classified Board-certified family practitioners in the specialist category. However, family physicians who were merely eligible for Board certification and family physicians who were neither Board-eligible nor Board-certified were grouped with the non-specialists (*id.* at 4a).[1]

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[1] The government acknowledged in proceedings in district court in this case that Board-eligible family physicians should have been included in the specialist category, and it represented that Board-eligible family physicians, like other Board-eligible physicians, thereafter would be included in that grouping (App., *infra*, 19a).

2. Respondents filed this action on October 8, 1976 in the United States District Court for the Eastern District of Michigan to challenge BC/BSM's classification of family practitioners within the three-category framework for determining prevailing charges (C.A. App. 1, 11-29). The initial plaintiffs were the Michigan Academy of Family Physicians, one Board-certified family practitioner, and two Board-eligible family practitioners (C.A. App. 19). Later, a Part B enrollee who was the patient of a family practitioner who was neither Board-certified nor Board-eligible was joined as a plaintiff (App., *infra*, 22a).

The district court held that the establishment of separate charge screens that distinguish non-Board-certified family physicians from other physicians violated the Medicare Act and that to the extent 42 C.F.R. 405.504(b) authorized the screens established by BC/BSM, it was invalid. The court first relied on 42 U.S.C. 1395u(b)(3), which requires the carrier to "take[ ] into consideration" the prevailing charges for "similar services" and to establish a ceiling based on the prevailing charge level that would cover 75% of the customary charges for "similar services" in the locality. In the court's view, these provisions required that similar services performed by physicians with different degrees of specialization be reimbursed at an equal rate. App., *infra*, 20a-21a. The court also concluded on the basis of testimony at trial that BC/BSM did not have an adequate factual or statistical basis for distinguishing among groups of physicians (*id.* at 19a).

In addition, the district court held that BC/BSM's procedure and the Secretary's regulation conflicted with 42 U.S.C. 1395a, which provides that Medicare beneficiaries "may obtain health services from any institution, agency, or person qualified to participate under [the Medicare program] if such institution, agency, or person undertakes to provide him such services." In the court's view, the maintenance of three charge screens impermissibly "tends to influence the patient's choice of a physician" (App., *infra*, 21a).

As a remedy, the district court ordered the Secretary and BC/BSM to establish two categories for determining prevailing charges: the first for all physicians, and the sec-

ond for chiropractors, podiatrists, and dentists (App., *infra*, 23a).

3.a. The court of appeals affirmed the district court's ruling but modified the remedy. As a threshold matter, the court of appeals rejected the Secretary's contention that the district court's exercise of jurisdiction under 28 U.S.C. 1331 was barred by 42 U.S.C. 1395ff and 42 U.S.C. 405(h) (App., *infra*, 5a-10a). The court acknowledged that under this Court's decision in *Erika*, judicial review of the amount of reimbursement for services under Part B of the Medicare Program is foreclosed (App., *infra*, 6a-7a). But the court noted that in the wake of *Erika*, several lower courts nevertheless "have strenuously endeavored to find jurisdiction" over challenges to certain aspects of the Medicare Program (App., *infra*, 7a), and it elected to do the same. The court relied in particular on the Ninth Circuit's decision in *Ringer* v. *Schweiker*, 697 F.2d 1291 (1982), which subsequently was reversed by this Court (*Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984)), and on the Fourth Circuit's decision in *Starnes* v. *Schweiker*, 715 F.2d 134 (1983), which subsequently was vacated and remanded by this Court for reconsideration in light of *Ringer* (*Heckler* v. *Starnes*, No. 83-1149 (June 4, 1984)). See App., *infra*, 7a.

The court of appeals acknowledged that "the eventual result of [this] suit may cause an increase in amounts of reimbursement" for services rendered by family physicians, who seek to be grouped with specialists whose services are reimbursed at a higher rate (App., *infra*, 7a). But the court held that the case fell outside the preclusion of review in 42 U.S.C. 1395ff with respect to matters pertaining to the amount of reimbursement because respondents were challenging the "mechanism" for computing the reasonable charge, and not the reasonable charge in a particular case (App., *infra*, 7a). The court stated that a "clear and convincing showing" of congressional intent to preclude review is required, and it declined to find a bar to judicial review here merely because Congress did not specifically provide for it in the judicial review section of the Medicare Act, 42 U.S.C. 1395ff (App., *infra*, 8a; see also *id.* at 9a-10a).

The court of appeals likewise concluded that judicial review under 28 U.S.C. 1331 was not barred by 42 U.S.C. 405(h), as incorporated into the Medicare Act by 42 U.S.C. 1395ii. The court acknowledged that in *Weinberger* v. *Salfi*, 422 U.S. 749 (1975), and subsequent decisions, this Court had held that the third sentence of Section 405(h) bars a court from exercising federal question jurisdiction to entertain a claim arising under the Social Security Act. But it noted that in *Salfi* and the other decisions, the Court at the same time permitted suits under 42 U.S.C. 405(g). Because there is no provision for review of Part B Medicare claims under 42 U.S.C. 405(g), the court reasoned, it would not construe 42 U.S.C. 405(h) to preclude judicial review here in a suit brought under 28 U.S.C. 1331. App., *infra*, 8a-10a.

b. On the merits, the court of appeals held that BC/BSM's calculation of the amount of reimbursement for family physicians' services by reference to the separate prevailing charge screens was invalid (App., *infra*, 10a-13a). The court explained that the "touchstone of [42 U.S.C. 1395u(b)(3)] is that similar services, once determined, are to be compensated equally, regardless of who performs them" (App., *infra*, 10a). It further found that BC/BSM's decision not to group family physicians with other specialists but to group them with chiropractors and podiatrists was not supported by the record of the trial the district court held in the case (*id.* at 11a). The court of appeals explained that its "decision to invalidate the regulation" was "bolstered" by its view that the reimbursement approach BC/BSM followed might create an added incentive for physicians to become specialized and for patients to seek specialized care (*id.* at 12a). The latter incentive, the court believed, was sufficient to support a finding that "the regulation as applied violates 42 U.S.C. 1395a, prohibiting infringement of a patient's free choice of a physician" (*ibid.*).

The court of appeals concluded, however, that "the district court's remedy, adopting sua sponte a single prevailing charge screen for all physicians, [went] too far" (App., *infra*, 12a-13a). It therefore remanded the case to the Sec-

retary "with instructions to consider similar services in an equal manner regardless of who performs that service" (*id.* at 13a).

REASONS FOR GRANTING THE PETITION

The decision of the court of appeals permitting judicial review of matters pertaining to the amount of benefits payable under the Part B Medicare Program is flatly inconsistent with this Court's holdings in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), and *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984). The Court recently granted certiorari and vacated the judgment of the court of appeals in another Medicare Part B case raising identical jurisdictional issues and remanded the case for further consideration in light of *Ringer*. See *Heckler* v. *Starnes*, No. 83-1149 (June 4, 1984). We request the Court to follow the same course here. On remand, the court of appeals also should reconsider its approach to discerning legislative intent with regard to the availability of judicial review in light of this Court's decision in *Block* v. *Community Nutrition Institute*, No. 83-458 (June 4, 1984).

1. Respondents in this case challenge the prevailing charge screens used to calculate the amount of Medicare benefits paid for services furnished by family physicians. As the Court's recent decision in *Heckler* v. *Ringer* makes clear, judicial review of such matters is barred by two separate provisions of the Social Security Act. The first is 42 U.S.C. 1395ff, which is the provision that governs the availability of judicial review for participants in the Medicare Program.

In 42 U.S.C. 1395ff(a), Congress provided that "the determination of the amount of benefits under part A [of the Medicare Program] shall be made by the Secretary in accordance with regulations prescribed by [her]." The Secretary is authorized to enter into contracts with fiscal intermediaries to make these initial determinations on her behalf. See 42 U.S.C. (& Supp. V) 1395h. An individual who is dissatisfied with the intermediary's determination is entitled to a hearing before an administrative law judge in the Department of Health and Human Services if the

amount in controversy is $100 or more and to judicial review as provided in 42 U.S.C. 405(g) if the amount remaining in controversy is $1000 or more. 42 U.S.C. 1395ff(b)(1)(C) and (2). On judicial review under 42 U.S.C. 405(g), the individual may seek a greater amount of benefits under Part A than was awarded at the administrative level by contending that the intermediary or the Secretary relied upon an invalid regulation. *Heckler* v. *Ringer*, slip op. 13; *Weinberger* v. *Salfi*, 422 U.S. 749, 762 (1975). Indeed, the Court held in *Ringer* that the individual must raise any challenge to a regulation under Part A in an action brought pursuant to 42 U.S.C. 1395ff and 405(g), and cannot bring a separate action challenging the validity of the regulation outside the special statutory review procedure by invoking the federal question jurisdiction of a district court under 28 U.S.C. 1331. *Heckler* v. *Ringer*, slip op. 10-13, 16-24.

Determinations and evidentiary hearings with respect to the amount of benefits on a particular claim under Part B of the Medicare Program are conducted by private insurance carriers under contract with the Secretary. As this Court noted in *Erika* (456 U.S. at 208), 42 U.S.C. 1395ff conspicuously fails to authorize judicial review of the "amount of benefits" under Part B, even though it expressly authorizes such review under Part A. In light of the statute's "precisely drawn provisions," the Court in *Erika* found this omission persuasive evidence that Congress had "deliberately * * * foreclosed" judicial review of benefit amount determinations under Part B. 456 U.S. at 208. The Court found this indication confirmed by the legislative history of Section 1395ff. 456 U.S. at 208-210.

This foreclosure of judicial review under Part B necessarily applies even where, as here, the plaintiff challenges a regulation issued by the Secretary that in turn has the effect of limiting the amount of benefits payable on an individual claim. In *Erika* itself, the plaintiff's claim to increased benefits was based in part on a challenge to instructions issued by the Secretary that limited the amount of benefits payable by the carrier. *Erika, Inc.* v. *United States*, 634 F.2d 580, 589 (Ct. Cl. 1980). And if

there were any doubt remaining on this score after *Erika*, it was dispelled by the decision in *Ringer*. That case involved a challenge to a regulation issued by the Secretary that barred the payment of any amount of benefits under Medicare for a particular medical service. The Court nonetheless held that judicial review of the regulation as it applied in the Part B Program was barred by 42 U.S.C. 1395ff and this Court's decision in *Erika*. *Heckler* v. *Ringer*, slip op. 5 n.4.

The court of appeals' holding permitting judicial review of the regulation at issue here therefore cannot be squared with *Ringer*. The court of appeals believed that the preclusion of review did not apply because respondents were challenging only the "mechanism" for computing the amount of benefits, not the actual amount paid in a particular case. App., *infra*, 7a. But in *Ringer* the plaintiffs likewise challenged the rule in issue on various substantive and procedural grounds without seeking an actual award of benefits (slip op. 7 & n.7), and yet the Court found that review under Part B was precluded.[2]

2. The correctness of the result indicated by 42 U.S.C. 1395ff standing alone—that judicial review of the regulation affecting the calculation of the amount of benefits under Part B is foreclosed—is confirmed by 42 U.S.C. 405(h).[3] The second sentence of Section 405(h) provides that "[n]o findings of fact or decision by the Secretary shall be reviewed by any person, *tribunal*, or governmental agency *except as herein provided*" (emphasis added). This sentence embodies a general rule under the Social Security Act that judicial review is unavailable except where and in the manner such review is expressly authorized by that

[2] In the absence of a concrete claim for benefits filed with the Secretary by a Part B enrollee (or by a physician who has accepted an assignment of such a claim), an enrollee or physician would not have standing to challenge the procedures used to calculate the amount of benefits payable on such a claim. *Heckler* v. *Ringer*, slip op. 6 n.6, 12, 17. And where an enrollee or physician *does* have a claim for benefits pending, this Court's decisions in *Ringer* and *Erika* make clear that judicial review of matters pertaining to the payment of that claim, including the mechanism for calculating the amount payable, is foreclosed.

[3] 42 U.S.C. 405(h) is made applicable to the Medicare Program by 42 U.S.C. 1395ii.

Act.[4] Because Congress has not affirmatively provided in the Social Security Act itself for judicial review under the Part B Medicare Program, the second sentence of Section 405(h) precludes such review.

The third sentence of 42 U.S.C. 405(h) further provides that "[n]o action" shall be brought against the Secretary under 28 U.S.C. 1331 "to recover on any claim arising under" the Medicare Act. The court of appeals' holding that the district court had jurisdiction over this suit under 28 U.S.C. 1331 directly contravenes this jurisdictional bar as well. The court of appeals believed that this bar was inapplicable here because respondents purport to challenge the "procedure" for calculating benefits, not the amount of benefits payable, on a particular claim (App., *infra*, 9a). But this Court has since explicitly held in *Ringer* that the preclusion in the third sentence of Section 405(h) cannot be avoided by labeling a challenge as "procedural" in nature (*Heckler* v. *Ringer*, slip op. 11-13). The court of appeals also construed the preclusion of review in the third sentence of Section 405(h) to be inapplicable because the Social Security Act does not otherwise provide for judicial review of Part B claims. This attempt to avoid the preclusive effect of Section 405(h) is inconsistent with *Ringer* too, because the Court in that case explicitly rejected the notion that the meaning of Section 405(h) somehow shifts depending on whether judicial review is available under Section 405(g). (*Heckler* v. *Ringer*, slip op. 19).

3. The court of appeals narrowly construed the preclusions of review in 42 U.S.C. 1395ff and 405(h) in part because of what it believed to be the absence of a "clear and convincing showing" that Congress intended to bar judiicial review in the circumstances presented here (App., *infra*, 8a, 9a). As this Court recently stressed, however, the proper inquiry is not whether there has been a clear and convincing showing of congressional intent in the strict evidentiary sense, as the court of appeals appeared to believe, but rather whether an "intent to preclude judicial review is

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[4] Because carriers make determinations on claims for benefits under Part B on behalf of the Secretary (see *Schweiker* v. *McClure*, 456 U.S. at 190), this preclusion of review applies equally to findings and decisions by the carriers under Part B.

'fairly discernible in the statutory scheme.'" *Block* v. *Community Nutrition Institute*, No. 83-458 (June 4, 1984), slip op. 10, quoting *Association of Data Processing Service Organizations, Inc.*, v. *Camp*, 397 U.S. 150, 157 (1970). For the reasons stated above, such an intent plainly is "fairly discernible"—indeed, it is compelled—by the combined force of 42 U.S.C. 1395ff and 405(h).[5]

[5] Because the courts below were clearly without jurisdiction, we have not asked this Court to review the court of appeals' holding on the merits that the Secretary's regulation permitting different charge screens for specialists is invalid. Nonetheless, it is our view that this holding also was plainly incorrect. The regulation, 42 C.F.R. 405.504(b), was promulgated in 1967 (32 Fed. Reg. 12601), just one year after the Medicare Program went into effect. See 42 U.S.C. 1395q(a)(1). It therefore is entitled to particular weight because "'it involved a contemporaneous construction of a statute by the [persons] charged with the responsibility of setting its machinery in motion, of making the parts work efficiently and smoothly while they are yet untried and new.'" *Zenith Radio Corp.* v. *United States*, 437 U.S. 443, 450 (1978), (brackets in original), quoting *Norwegian Nitrogen Products Corp.* v. *United States*, 288 U.S. 294, 315 (1933). The court of appeals believed that the regulation was inconsistent with the reference in 42 U.S.C. 1395u(b)(3) to charges made in the locality for "similar services," which the court read to require identical levels of reimbursement irrespective of who performs the services. App., *infra*, 10a-12a. There are two flaws in this analysis.

First, the performance of an examination or other service by a specialist is not necessarily equivalent to the performance by a nonspecialist. The specialist brings his added expertise to bear. It presumably is this difference in expertise that has led the medical profession to recognize specialization by instituting a procedure for Board certification and that has led to the different charging patterns in some localities on which a carrier may base different charge screens. It certainly is reasonable for the Secretary to permit a carrier to take those factors into account in calculating the overall "reasonable charge"—the ultimate standard for purposes of Medicare reimbursement. 42 U.S.C. 1395u(b)(3)(B). Second, 42 U.S.C. 1395u(b)(3) does not state that payment must be identical for "similar services." It only requires the carrier to "take[ ] into consideration" the prevailing charge in the locality for "similar services" and sets a ceiling by reference to that standard. This framework allows the Secretary and the carriers flexibility in their approach to the computation of a "reasonable charge" for services. As noted above (see note 1, *supra*), the Secretary and BC/BSM have agreed to group family physicians who are Board-certified or Board-eligible with other specialists. Those family physicians who are not even Board-eligible are grouped separately. That plainly is a rational classification system.

CONCLUSION

The petition for a writ of certiorari should be granted, the judgment of the court of appeals should be vacated, and the case should be remanded to the court of appeals for further consideration in light of *Heckler* v. *Ringer*, No. 82-1772 (May 14, 1984), and *Block* v. *Community Nutrition Institute*, No. 83-458 (June 4, 1984).

Respectfully submitted.

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JULY 1984

APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.,
PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND
RICHARDS S. SCHWEIKER, SECRETARY OF HEALTH
AND HUMAN SERVICES, DEFENDANTS-APPELLANTS

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF MICHIGAN

[Filed Feb. 23, 1984]

Before: JONES, Circuit Judge; PECK and BROWN, Senior Circuit Judges.

PECK, Senior Circuit Judge. The principal question raised in this appeal is the validity of the method adopted by the Department of Health and Human Services (HHS) by which certain eligible individuals receive reimbursement for services performed by physicians and other individuals pursuant to the federal Health Insurance for the Aged and Disabled Act (Medicare), 42 U.S.C. § 1395 *et seq.* The Michigan Academy of Family Physicians (Michigan Academy) filed suit against Blue Cross and Blue Shield of Michigan (BC/BSM) and Richard S. Schweiker, Secretary of HHS (Secretary). The complaint alleges that the classification of certain family physicians separately from other physicians with similar qualifications, and together with non-allopathic doctors (such as chiropractors and podiatrists), contraverted the statutory mandate of Congress as expressed in the Medicare Act. A violation of due process and equal protection rights under the fifth amendment of the United States Constitution is also claimed. The district court, after finding jurisdiction, held that the classification

violated the Medicare Act, §§ 1395u(b) (3) & 1395a, and ordered the Secretary to include all family physicians with other medical doctors. BC/BSM and the Secretary appeal.

BACKGROUND

The Medicare Act consists of two programs. Part A provides insurance for hospitalization and post-hospital services. 42 U.S.C. § 1395c-1395i-2. Part B, at issue in this case, provides insurance for supplemental medical care. 42 U.S.C. § 1395j-1395w. Under part B eligible individuals may voluntarily enroll in the health insurance program by paying a monthly premium. Members enrolled in the program may request reimbursement of eighty per cent of the reasonable charges, as defined by the insurance carrier, of the services rendered, or assign the right of reimbursement to their physician. 42 U.S.C. § 1395u(b)(3)(B)(ii).

As directed by statute, the Secretary is required to contract with an insurance intermediary to administer the Medicare part B program. 42 U.S.C. § 1395u. According to statute, the carrier is responsible for determining reasonable fees for covered services in order to calculate the applicable reimbursement amount. *Id.* The Act further provides that a carrier, in calculating these reimbursements, is to consider "the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services." 42 U.S.C. § 1395u(b)(3). Price ceilings are placed on the calculation of the reasonable fee so that such fee is not reasonable if it exceeds either the prevailing or customary fees as calculated under the Medicare Act.[1]

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[1] 42 U.S.C. § 1395u (b)(3) provided a complex methodology for calculating the specific amounts of each category. The section provides in pertinent part:

> In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31,

In August, 1967, the Secretary validly promulgated 42 C.F.R. § 405.504. 32 Fed. Reg. 12600 (1967). After first restating the definition of prevailing charges, the regulation in part B permits carriers to establish separate prevailing charges for "specialists" and "non-specialists" and specifically provides that carriers can develop more than one set of prevailing charges based on fee patterns in a local area. As a practical result of this regulation, carriers developed separate and distinct prevailing charges for different types of physicians. Under the regulation, patients receiving one type of service from a specialist are entitled to incur a higher reasonable charge, and therefore to receive a larger reimbursement than if they received the identical service from a non-specialist.

FACTS

Beginning in 1966 the Secretary contracted with BC/BSM to administer the Medicare part B program in the state of Michigan. BC/BSM, in initially determining charges, lumped physicians into three groups for the purpose of calculating prevailing charges in each geographic locality in Michigan. One group consisted exclusively of hospital internists and other hospital specialists. A second group consisted of certified specialists. The final group consisted of general pratitioners and other non-specialists. Thereafter, with the passage of 42 U.S.C. § 1395x(r), including other non-allopathic doctors such as chiropractors, dentists, and podiatrists in the Medicare Program, BC/BSM restructured its prevailing charge screens, devising the present system. Group 1 consisted of hospital personnel and other internists. Group 2 consisted of specialists and board certified specialists or board eligible special-

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1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made. . . .

ists. Group 3 included general practitioners, board eligible family physicians, and other non-physicians added in the 1972 amendment to the Medicare statute.

Under the Medicare system existing in Michigan, and in several other states, a physician determines what services he will perform for a patient. If covered by the Medicare Act, he assigns the service a procedural code or number from those denoted by the Secretary. BC/BSM, after determining what type of physician performed the service, will thereupon reimburse the patient, or his assignee, based in part on the prevailing charge screen within which the physician is classified. In practice, enrollees receiving services from a specialist would receive a larger reimbursement amount than if they received similar services from a general practitioner performing the same service.

The Michigan Academy, a nonprofit Michigan corporation representing family physicians throughout the state, filed suit against BC/BSM and the Secretary, arguing that the Michigan reimbursement procedure violated the Medicare statute and was unconstitutional. It alleged that the use of prevailing charge screens ignored the Medicare Act's mandate to reimburse equal amounts for similar services performed. Further, Michigan Academy alleged, the use of prevailing charge screens had an impermissible impact on an enrollee's choice of a physician and unduly infringed the free practice of medicine. Alternatively, Michigan Academy argued that the procedure denied its members equal protection and due process under the fifth amendment of the United States Constitution since 42 C.F.R. § 405.504 irrationally classified them together with non-allopathic doctors rather than with other specialists with whom they shared similar qualifications and talents.

At trial no witness for Michigan Academy or BC/BSM could explain why family physicians were separately categorized from all other medical specialists. BC/BSM, in addition, indicated that its classifications were not based on any particular statistical data but that they had apparently evolved over the years.

At the close of all the evidence, the district judge held that § 405.504 violated the Medicare Act. He found that

the Medicare Act mandated equal reimbursements for similar services performed despite the type of physician performing them, and that the prevailing charge screens improperly infringed on a patient's free choice in selecting a physician. At the same time, while indicating on several occasions that he felt the regulation was irrational and without support in the trial record, the district judge specifically refused to rule that the regulation is unconstitutional. Holding only that the regulation violated the Medicare Act, the district judge ordered the Secretary to reclassify all physicians together, including family physicians, in one single prevailing charge screen.

On appeal, BC/BSM and the Secretary argue initially that the district court lacked jurisdiction to render its decision. In the alternative, they contend that § 405.504 is a permissible interpretation by HHS of the language of the Medicare Act and that the classification of certain family physicians is constitutional. Even if this court disapproves § 405.504 and finds it unconstitutional, BC/BSM and the Secretary argue, the district judge's remedy of restructuring the prevailing price screens was improper. This court, they contend, should remand the case to the Secretary to allow for a proper restructuring of the reimbursement procedure.

JURISDICTION

We initially turn to the thorny question of whether the district court had jurisdiction to render a decision in this case. In its brief BC/BSM contends that § 205(h) of the Social Security Act, 42 U.S.C. § 405(h), as interpreted by the courts, precludes jurisdiction in this case. BC/BSM first characterizes this cause as a dispute over the amount of reimbursements owed a recipient under the Medicare part B program, an area in which Congress specifically foreclosed judicial review. Since § 1395ff provides a complex administrative methodology for resolving such appeals, BC/BSM urges, no judicial review of such matters is available. In the alternative, they contend that even though § 1395ff is silent on the question of judicial review of decisions by the Secretary made in the course of implementing the Medicare

part B program federal question jurisdiction under 28 U.S.C. § 1331 is specifically precluded by § 405(h).

It is well-settled that there is no judicial review of disputes simply concerning the amount of reimbursement or an individual's eligibility to receive Medicare part B benefits. The Supreme Court in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), interpreting 42 U.S.C. § 1395ff,[2] held that Congress clearly and convincingly intended that no judicial review of such questions was permissible. The Court found that the legislative history of § 1395ff, as well as the presence of an elaborate administrative review mechanism, clearly showed Congress's intent to bar such disputes from judicial consideration. Id. at 208-09. Among the numerous concerns Congress had mentioned and the Court found important was the need to stem the potential avalanche of litigation concerning the amount of reimbursement. *Id.* In finding that no federal question jurisdiction existed for adjudicating questions involving the amount of reimbursements under Medicare part B, the Supreme Court left open

[2] Section 1395ff provides in pertinent part:

> (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.
>
> (b)(1) Any individual dissatisfied with any determination under subsection (a) as to—
>
> > (A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or
> >
> > (B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title, or section 1818, or section 1819, or
> >
> > (C) the amount of benefits under part A (including a determination where such amount is determined to be zero)
>
> shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).
>
> (2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000. . . .

the question of whether all claims involving disputes over the administration of part B reimbursements were similarly foreclosed.

In the wake of *Erika*, however, courts have strenuously endeavored to find jurisdiction over various types of challenges to the procedural aspects of the Medicare part B program despite the language of § 1395ff. The Supreme Court itself permitted a constitutional challenge to the hearing process which Congress permitted under § 1395ff. *Schweiker* v. *McClure*, 456 U.S. 188 (1982). Other federal courts have followed suit. *Colonial Penn Insurance Co.* v. *Heckler*, 721 F.2d 431 (3d Cir. 1983); *Starnes* v. *Schweiker*, 715 F.2d 134 (4th Cir. 1983); *Ringer* v. *Schweiker*, 697 F.2d 1291 (9th Cir. 1982), *cert. granted sub nom. Heckler* v. *Ringer*, 103 S. Ct. 3535 (1983).

In this case BC/BSM contends this suit involves simply a dispute over the amount of reimbursement due. In a word, BC/BSM contends, Michigan Academy simply is seeking to have family physicians and their patients moved to the more lucrative specialist screen, boiling down to an argument for an increase in amounts reimbursed. *Erika*, it concludes, should bar this suit outright. This argument, however, is without merit.

While the eventual result of this suit may cause an increase in amounts of reimbursement, that does not necessarily follow. In some cases the result might be an increased amount of reimbursement, and in others, a reduction in reimbursement could occur. Michigan Academy, at bottom line, is challenging the overall mechanism for determining the amounts of reimbursements, not the actual value of any particular reimbursement.

More importantly, unlike the situation in *Erika*, *supra*, there is no indication that Congress intended to preclude our jurisdiction over suits challenging procedural aspects of the Medicare program, despite the language of § 1395ff or § 405(h). Section 1395ff, by its terms as interpreted by the Supreme Court, precludes judicial review of decisions by the carrier concerning amounts of reimbursements, but is silent on the question of reviewing decisions of the Secretary made in implementing the overall Medicare part B pro-

gram. *Erika, supra; Starnes, supra.* At the same time, Congress provided for an elaborate administrative review of the carrier's decisions. *See* 42 U.S.C. § 1395ff(a). No similar procedure was developed for review of disputes such as that raised in this case. This court has pointed out that where no mechanism for reviewing administrative decisions is available, courts should be slow to find Congress intended such a bar absent a clear and convincing showing either in the particular act's language or legislative history. *Chelsea Community Hospital, SNF* v. *Michigan Blue Cross Ass'n*, 630 F.2d 1131, 1134 (6th Cir. 1980) (citing *Association of Data Processing Service Organizations* v. *Camp*, 397 U.S. 150 (1970) and *Abbott Laboratories* v. *Gardner*, 387 U.S. 136 (1967)) (jurisdiction exists for reviewing pre-1973 claims disputing the amount of reimbursement under part A of the Medicare Act where no other mechanism for review of such determinations available). With this in mind, we hesitate to bar judicial review over this suit simply because Congress failed to specifically allow for our review in § 1395ff.

BC/BSM and the Secretary argue, however, that even if the language of § 1395ff does not specifically foreclose our review in this case, 42 U.S.C. § 405(h), as incorporated into the Medicare Act by 42 U.S.C. § 1395ii, provides clear support for the contention that Congress intended to preclude all judicial review. They contend that the Supreme Court specifically held that no jurisdiction existed for claims arising under the Social Security Act based on the clear and unambiguous language of this section. *Weinberger* v. *Salfi*, 422 U.S. 749 (1975) (where no other jurisdiction was provided under the Social Security Act, no judicial review could lie). Since this precise provision was incorporated into the Medicare statute, they argue, and § 1395ff does not specifically provide for judicial review of part B claims, it should be similarly construed in this case. We disagree.

In *Salfi, supra*, the Supreme Court specifically referred to the alternative methods available for judicial review of Social Security disputes. *Id.* at 757 (jurisdiction available under § 405(g)). Later Supreme Court decisions have read-

ily followed *Salfi* in barring federal question jurisdiction, but at the same time permitted suits under § 405(g). *Califano* v. *Yamasaki*, 442 U.S. 682, *remanded sub nom. Yamasaki* v. *Harris*, 607 F.2d 329 (9th Cir. 1979); *Mathews* v. *Eldridge*, 424 U.S. 319 (1976).

In *Herzog* v. *Secretary of HEW*, 686 F.2d 1154 (6th Cir. 1982), this court, while barring judicial review of statutory challenges to amounts of reimbursement under part B of the Medicare Act, specifically referred to the elaborate administrative mechanism of § 1395ff as an alternative avenue of review. The court in *Herzog* pointed out that Congress intended to direct such disputes through administrative process rather than overload the federal courts with a flood of small claims. *Id.* at 1158. *See also Erika*, *supra*; *Starnes*, *supra*.

Unlike *Herzog*, however, this dispute involves not a challenge to an individual amount of reimbursement, but instead a challenge to a regulation by the Secretary establishing the procedure under which reimbursement schedules should be determined. Further, Congress did not provide any mechanism to review such decisions of the Secretary in this type of case. In the absence of federal question jurisidiction, therefore, the Secretary apparently would have unbridled discretion to promulgate any regulation he chose. Courts confronted with this dilemma have held that Congress did not intend to preclude federal jurisdiction over such causes. *Colonial Penn Insurance Co.*, *supra*; *Starnes*, *supra*; *Ringer*, *supra*. *Cf. Chelsea Community Hospital*, *supra* (court will entertain suit where no means of reviewing pre-1973 reimbursements under part A of Medicare Act and nothing to indicate Congress intended to foreclose such jurisdiction). Given the presumption favoring judicial review and absent a clear and convincing showing that Congress intended the contrary,[3] we conclude that the district court correctly found federal question ju-

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[3] *Chelsea Community Hospital, SNF v. Michigan Blue Cross Ass'n*, *supra* (citing *Ass'n of Data Processing Service Organizations v. Camp*, *supra*; *Abbott Laboratories v. Gardner*, *supra*).

risdiction under 28 U.S.C. § 1331 to render a decision in this case.

STATUTORY CHALLENGE

Having determined that the district court properly exercised jurisdiction, we turn to the question of whether the Secretary's method of determining reasonable charges for calculating the amount of reimbursements under part B of the Medicare Act in the state of Michigan conformed with the statutory directives of 42 U.S.C. § 1395u(b)(3). After careful analysis of the Medicare Act, its legislative history, and the procedure selected by the Secretary, we find the present methodology impermissible.

Devising procedures for calculating reasonable charges for purposes of reimbursements § 1395u(b)(3) of the Medicare Act specifically requires the Secretary to focus on the customary and prevailing charges for similar services in a locality. The obvious common denominator throughout § 1395u(b)(3) is "similar services." Though not defined by the statute, the language plainly stands for the proposition that once a particular service is determined, all services of a similar nature are to be compensated or reimbursed at the customary, or prevailing rate. The touchstone of this language is that similar services, once determined, are to be compensated equally, regardless of who performs them, at a particular level, determined by the carrier. *See* 42 U.S.C. § 1395u(b)(3); *Alexander* v. *Schweicker* [*sic*], 516 F. Supp. 182 (D. Conn. 1981).

Despite this plain statutory language, and without explanation, the Secretary promulgated 42 C.F.R. § 405.504 providing that carriers, in calculating prevailing charges for a particular locality, could develop separate prevailing charges for physicians who were specialists. Such prevailing charges, as defined in § 405.504(2) were to be based on statistics, reflecting customary charging patterns in the locality. In implementing this program in Michigan, the Secretary approved BC/BSM's plan of lumping physicians and non-physicians into three categories, separating specialists from non-specialists except in the case of family physicians. Under this approach, once a physician or other medical pro-

vider selected a particular service to perform he chose the appropriate procedure code for the service. Reimbursement for that service was then determined on the basis of the charge screen to which the particular physician or non-allopathic doctor was assigned. Under this approach, a general practitioner would receive a smaller sum than would a specialist for a routine office visit, despite their selections of identical procedural codes.

BC/BSM and the Secretary in an effort to reconcile the obvious inconsistency between the language of § 1395u(b)(3) and the regulation, argue that § 405.504 attempts to further the legislative intent to have reimbursements under the Medicare Act reflect actual charging patterns in the community. They refer to several instances where Congress stated its concern about the possibility of artifically distorting fees charged by physicians through undue interference with physicians' fees. At trial, however, when questioned about the statistical basis of the Michigan prevailing charge screens, particularly in the separation of family physicians from all other medical specialists (even though they have similar qualifications and perform similar services), no witness could produce actual data demonstrating the significance of such a division. Dr. Boyles, testifying at the trial, stated that the statistical evidence supporting the entire plan was at best "skimpy".[4] Nor could witnesses point to any actual evidence demonstrating that family physicians and non-physicians, such as chiropractors or podiatrists, charged similar amounts for similar services. In fact, the record indicates that the revisions of the prevailing charge screens in 1973 were primarily based on the evolution of the original set of screens which had been basically selected without the benefit of actual data.

We recognize the fact that regulations promulgated by the Secretary must be granted deferential consideration

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[4] Paul Riesel, Chief of the Physician Practitioner Reimbursement Branch in the Bureau of Program Policy of the Health Care Financing Administration in Baltimore, Maryland, stated that no instructions were given to the carriers for determining prevailing charges and there was no apparent reason for separating family physicians from other specialists with similar qualifications.

and that we should exercise caution in overturning them. *NLRB* v. *Bell Aerospace Co. Division of Textron, Inc.*, 416 U.S. 267, 274-75 (1974). In this case, in addition to there being no justification for its promulgation, and the obvious inconsistency with the plain language of the Medicare statute, we also hold that this regulation is irrational and is invalid.[5]

Our decision to invalidate the regulation is bolstered by the district court's findings concerning the pernicious impact of this system on the cost of medical care. Several witnesses, including former Secretary of HEW Joseph A. Califano, pointed to the severe inflationary impact the system produced. In addition, due to more lucrative reimbursements of specialists, doctors had an added incentive to become specialized and over-utilize technology leading to increased medical costs. At the same time the system, by encouraging specialization, forced patients to seek specialists even for routine health care. Primary care, at the same time, tended to fall off as more and more doctors entered specialty fields. In passing the Health Professions Educational Assistance Act of 1976, Congress clearly expressed its concern for the continued need to protect and encourage primary medical care. *See* Pub. L. No. 90-484, 90 Stat. 2243 (reference to congressional intent to improve maldistribution of physicians and improve availability of primary health care). As was plainly demonstrated at trial, the maldistribution of physicians was significantly enhanced through the use of prevailing charge screens. As a corollary to our holding, therefore, we conclude that these findings by the district court are sufficient to support its determinations that the regulation as applied violates 42 U.S.C. § 1395a, prohibiting infringement of a patient's free choice of a physician.

While we hold today that 42 C.F.R. § 405.504 is invalid, due to its failure to recognize the statutory mandate that similar services be considered identically regardless of who performs them, we think the district court's remedy,

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[5] Having found this regulation statutorily unsound, we need not address the constitutional issues also raised in this case.

adopting sua sponte a single prevailing charge screen for all physicians, goes too far. In a case as complex as this one, we seek the expertise of the government agency to which Congress has assigned responsibility for implementing the statute. Our function on review must be one that is clearly limited to providing correct guidelines within which the knowledge and experience of the specialized agency is called into play. In so doing the policies and goals of the statute may more closely be pursued and implemented. *Industrial Union Dept.* v. *American Petroleum Institute*, 448 U.S. 607 (1980); *St. Louis University* v. *Blue Cross Hospital Service*, 537 F.2d 283 (8th Cir.), *cert. denied*, 429 U.S. 977 (1976).

We therefore remand this case to the Secretary for reconsideration of the Michigan reimbursement plan under part B of the Medicare program with instructions to consider similar services in an equal manner regardless of who performs that service.

Remanded.

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 81-1202

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL., PLAINTIFFS-APPELLEES,

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN AND RICHARD S. SCHWEIKER, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS-APPELLANTS

BEFORE: JONES, *Circuit Judge;* PECK AND BROWN, *Senior Circuit Judges.*

[Filed Feb. 23, 1984]

JUDGMENT

ON APPEAL from the United States District Court for the Eastern District of Michigan.

THIS CAUSE came on to be heard on the record from the said District Court and was argued by counsel.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this court that this case is remanded to the Secretary for proceedings not inconsistent with this opinion.

Each party is to bear its own costs on the appeal.

ENTERED BY ORDER OF THE COURT

/s/ _____
JOHN P. HEHMAN,
Clerk

A TRUE COPY.

Attest:

/s/ _____
TOM ENNIGNUS
Deputy Clerk

APPENDIX C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Civil Action No. 76-72082

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, A NON-PROFIT ASSOCIATION, CHARLES FARBER, M.D., GLENN W. HOUSE, M.D., LESTER WEBB, M.D. AND CAROL A. DIEDRICH, PLAINTIFFS

v.

BLUE CROSS AND BLUE SHIELD OF MICHIGAN, AND PATRICIA HARRIS, SECRETARY OF HEALTH AND HUMAN SERVICES, DEFENDANTS

[Filed Dec. 30, 1980]

OPINION

This is an action by plaintiffs seeking judicial review of the action of the Secretary of Health and Human Services in setting reimbursement rates at different levels for certain groups of physicians under Title XVIII of the Social Security Act, Part B, 42 USC 1395, et seq.

Plaintiffs are the Michigan Academy of Family Physicians, a voluntary non-profit association of family physicians, three individual family practitioners, and a Medicare beneficiary.

Defendants are Blue Cross/Blue Shield of Michigan (BC/BSM) a Michigan non-profit corporation which has been designated as the fiscal intermediary and carrier under the Medicare Act for the State of Michigan and the Secretary of Health and Human Services, the Administrator of the Medicare Program (The Secretary).

At issue is the legality of treating certain family physicians differently from all other physicians in reimbursing them for medical services under Medicare. Such discrimination is illegal for the reasons stated below.

The American Board of Family Practice was established in 1969, and from 1969 until mid-1978 a physician could be

qualified to sit for examination by the American Board of Family Practice if he or she had completed a three-year residency program, or if he or she had practiced for a period of six years and completed a minimum of 50 hours continuing education for each of the six years. Effective July 1, 1978, a physician, to be qualified to sit for examination by the American Board of Family Practice, had to have completed a three-year residency program, and, in addition, take the certification examination. To continue to be board certified, one must retake the examination every six years, and to be either board certified or board eligible one must pursue 50 hours of continuing medical education.

Federal health insurance for the aged, popularly known as Medicare, was enacted by the Congress in 1965, and amended in 1970. The system contains two substantially distinct parts, one providing insurance for hospital and related post-hospital services, known as Part A, 42 USC 1395c-1395i-2 (Supp V), the other providing insurance for supplementary medical services, primarily physicians' services, known as Part B. This litigation concerns only Part B of the Medicare Act.

Part B of the Medicare Act is a voluntary health insurance program which operates in a manner similar to private health insurance programs. Eligible individuals enroll in the program and agree to pay a monthly premium established by the Secretary. 42 USC 1395r (b) and (c). The premiums, together with amounts contributed by the federal government, are deposited in the Federal Supplementary Medical Insurance Trust Fund, which is wholly distinct from the Fund established for Part A. 42 U.S.C. 1395t.

The Medicare Statute provides that Medicare beneficiaries are entitled to reimbursement for medical services provided in the amount of 80 percent of the physician's reasonable charge for covered health services. 48 USC 1395*l*(a)(1)(B). 42 USC 1395u defines "reasonable charge" as the lower of the charges a physician customarily charges for the same service and the prevailing charge in the community for that service. The prevailing charge is statutorily defined as an amount which is equal to the seventy-fifth

(75th) percentile of the charges for the same service by other physicians in the same locality.

An individual under Part B who obtains a covered service can pay for this service and request reimbursement at the rate of 80 percent of the "reasonable charge," or assign the right to reimbursement to the person providing this service, who can collect as an assignee of the beneficiary, 42 USC 1395u(b)(3)B(ii). By accepting assignment, a physician agrees to demand no more of a patient that [*sic*] the reasonable charge determined by the Secretary. Accordingly, the patient is only responsible for the 20 percent of the reasonable charge not paid for by Medicare. A physician who does not accept assignment has no statutory limitation on the amount he or she may charge a Medicare beneficiary. However, the physician may not bill Medicare directly, but rather must recover directly from the beneficiary for the services performed.

Upon the inception of the Medicare program, and to this day, BC/BSM has neither developed a procedure to determine what types of professional services are similar to others for purposes of establishing prevailing charges in accordance with 42 USC 1595u(b)(3), nor carried out a statistical study to determine different types of providers' actual charge patterns for particular services, pursuant to 42 C.F.R. § 405.504(b). Instead, BC/BSM in 1966 established three "screens" to determine the prevailing fee calculations for Medicare "reasonable charge" determination in Michigan. One screen contained board certified and board eligible internists for hospital visits; another screen contained board certified and board eligible specialists, and board certified and board eligible internists for services other than inpatient hospital visits; and the third screen consisted of board certified and board eligible family physicians, nonboard eligible family physicians and various nonphysician groups, such as podiatrists, chiropractors, and dentists.

In February 1973, BC/BSM redefined the three screens. The screens, as they still exist today, were realigned as follows: Screen one is for general practitioners or nonspecialists. Included in this screen are DOs and MDs who

are general practitioners, non-board certified family practitioners, chiropractors, podiatrists, and dental surgeons. Screen two is made up of internists for inpatient hospital services only. Contained in this screen are DOs and MDs who are board certified and non-board certified internists for inpatient hospital services only. Screen three is a specialists' screen. It is made up of DOs and MDs who are board certified family practitioners, and board certified and non-board certified specialists. Physicians who engage in a group practice, and who agree to bill under a group number, are placed within the specialists' screen for purposes of determining reasonable charges in Michigan, regardless of the qualification of the physicians in the group.

From these three groupings, a 75th percentile was established, and thus, in determining the prevailing fee for an office visit, the charges of all the physicians within the so-called "specialty screen" would be lumped together to determine the "reasonable charges." Once a physician is classified as either a specialist or a non-specialist by the carrier, all billings submitted for all types of procedures performed by that physician are priced against prevailing charges applicable to the screen in which he or she is placed. The significance of this procedure with respect to the present case is that the 1973 modification of the screens placed board-certified family physicians in the so-called specialists' screen. Family physicians who were not board certified, whether or not they had completed a certified residency program in family practice, and no matter how long they had been practicing as family physicians, remained in the GPN, or non-specialty screen. These family physicians constitute the only physicians not placed within a specialists' screen, and they are the only physicians whose reasonable charges are determined in part by the charges of non-physicians, such as podiatrists and chiropractors.

At issue is the validity of prevailing charge screens used by BC/BSM as an upper limit on reimbursable charges for physicians' services under Part B.

Plaintiffs claim that there is no factual basis whatever to justify treating family physicians differently from all other

physicians, and not only does the discrimination against them have no rational basis theoretically, it makes less sense in application. Even defendants have admitted at trial that there is no rationale for treating board eligible family physicians as non-specialists. Plaintiffs further contend that the change from a dual screen prevailing fee concept to a one screen prevailing fee concept would result in a lower payment for services, render the Medicare Program more efficient, and would more correctly bring into play market forces.

Plaintiffs contend that the creation and maintenance of special family physician differentials for purposes of determining reasonable charges violates the Fifth Amendment, that the maintenance of the dual reimbursement screen violates plaintiffs' right to procedural due process in that it deprives the plaintiffs of property rights based upon an irrebuttable presumption that plaintiffs' physician services are worth less than, and are not similar to, all other physician services, presumptions not necessarily nor universally true in fact; and that defendants' creation and maintenance of separate reimbursement screens, whereby family physicians are segregated from all other allopathic physicians for determination of Medicare reimbursement violates the express provisions of 42 USC 1395u(b)(3) and the applicable regulations, 42 C.F.R. 405.504(b).

Indeed, the evidence bears out plaintiffs' contention. The testimony in the case showed that there was no factual basis whatever to justify treating family physicians differently from all other physicians, either at the onset of the medical care program or presently. And, as is clear from a review of the screening procedure itself, BC/BSM in its private insurance does not distinguish between specialists and non-specialists, but rather pays a certain amount for the service regardless of who furnishes that service.

42 USC 1395u(b)(3) sets forth the obligation of the Secretary and carrier under Part B of the Medicare program. It provides, in pertinent part:

> "In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for *similar*

services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for *similar services*. No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i), the prevailing charge recognized by the carrier and found acceptable by the Secretary for *similar services* in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for *similar services* in the same locality during the last preceding calendar year . . ." (Emphasis Added)

Further, 42 USC 1395(a) provides that nothing in the Medicare Act shall be construed to authorize the federal government or its agents to supervise or control the practice of medicine or the manner in which medical services are provided, or the selection, tenure, or compensation of officers or employees of health care providers, or the selection of medical care providers by beneficiaries.

The applicable regulation under 42 USC 1395 is 42 CFR 405.504(b). This regulation provides:

"The range of prevailing charges in a locality may be different for physicians or other persons who engage in a speciality practice or service than for others. Exisiting differentials in the level of charges between different kinds of practice or service could, in some localities, lead to development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns."

Plaintiffs contend that defendants have never used the test of similar services as a basis for determining any physician's prevailing charge, and that the current reimbursement system of BC/BSM deviates from the statutory direc-

tives. They point out that for purposes of determining any particular physician's "prevailing charge," defendant BC/BSM determines whether the physician is a "specialist" or "general practitioner" under its own definition. Once this decision or definition is rendered, that particular physician will receive reimbursement at the same rate as all other "specialists" or "general practitioners," no matter what type of procedure is being performed. Plaintiffs argue that no recognition of similarity of services exists in defendant's reimbursement decisions, even though a similarity of service is a standard by which such distinctions are to be made.

It is clear that the statute, 42 USC 1395u(b)(3) uses as the statutory scheme the customary charge of physicians for similar services in a specific locality. The statute further provides that nothing in the Medicare Act shall be construed as authorizing the federal government or its agent to supervise or control the practice of medicine or the manner in which medical services are provided, or the selection of Medicare providers by beneficiaries.

20 C.F.R. 405.504(b) authorizes a carrier to separate customary charges for similar services in computing the 75th percentile prevailing fee reasonable charge ceiling. In so doing, the regulation conflicts with the statute, which mandates that customary charges of physicians for similar services be the test for reimbursement.

The maintenance of three screens in the State of Michigan clearly violates 42 USC 1395(a) because it tends to influence the patient's choice of a physician, and reduces Medicare recipients' reimbursement solely by virtue of their choice of the type of physician to perform a particular medical service. The effect of the maintenance of these screens is to cause a Medicare recipient to go to a specialist for a particular service, or, if the recipient is not sophisticated enough to know the provisions, to cause him or her to suffer a lesser reimbursement than a person who had chosen a specialist to perform the type of medical service required. Even 20 C.F.R. 405.504(b) requires that any distinction between types of physicians for purposes of establishing prevailing fee schedules must be based upon a statistically valid analysis of the range of charges. The rec-

ord in this case failed to show any statistically valid analysis of the billings of allopathic family physicians as compared with other types of family physicians.

There is no basis to justify the segregation of allopathic family physicians from all other types of physicians. Such segregation is not rationally related to any legitimate purpose of the Medicare statute. To lump MDs who are family physicians, but who have chosen not to become board certified family physicians for whatever motive, with chiropractors, dentists, and podiatrists for the purpose of determining Medicare reimbursement defies all reason.

The effect of this can be dramatically shown in the case of Plaintiff Carole A. Diedrich, a Medicare recipient who has been disabled and has been a recipient since 1975. Her physician is Philip Lange, M.D., a family physician who has practiced in Lansing, Michigan, for approximately 23 years. Dr. Lange sees patients ranging in age from newborns through the very old, and treats a vast majority of medical conditions. He is on the staffs of St. Lawrence Hospital, Sparrow Hospital, and the Ingham County Medical Center. He is a grduate of the Wayne State University Medical School, and did a one-year internship and one-year residency in general medicine at St. Lawrence Hospital. He is an instructor at Michigan State University, and teaches students in family medicine. He is neither board eligible nor board certified by the American Board of Family Practice. For most procedures, Dr. Lange does not accept assignment from the Medicare program. He does not accept assignment from Medicare for certain office calls, and charges patients $50 for a comprehensive examination, and $18 for a routine office visit.

Where a physician does not accept an assignment, the patient is responsible for whatever charge the physician renders, the patient receiving reimbursement from Medicare in the amount of 80 percent of the reasonable fee, as determined by the carrier. The prevailing fee limitation for 1980 in the Lansing area is as follows: initial comprehensive visit, non-specialist $25, specialist $50; follow-up office visit, non-specialist $10.70, specialist $12.30. Solely as a result of Mrs. Diedrich's choice of Philip Lange as her

treating physician, she, while paying the same premium as other Medicare recipients, received less coverage for services peformed than had she chosen a physician defined as a "specialist."

This example dramatically shows the effect of the screens established by BC/BSM in the reimbursement of Medicare recipients, and is the heart of plaintiffs' complaint in this action. Simply stated, Mrs. Diedrich, while paying the same premium as other Medicare recipients, receives less coverage for services performed for primary care because she goes to Dr. Lange than she would have received had she chosen a physician defined as a specialist.

The establishment of separate screens segregating non-board certified family physicians from all other physicians clearly is violative of the Medicare Act. To the extent that 20 C.F.R. 405.504(b) authorizes the screens set up by the defendants, that regulation is invalid.

Because the Court has found that the actions of defendants violate the Medicare statute, 42 USC 1395 et seq., it need not consider the constitutional arguments raised by plaintiffs.

A mandatory injunction will issue, directing defendants to provide that all physicians be included in a single screen, separate from the screen for chiropractors, podiatrists, and dentists.

Plaintiffs may tax costs. A judgment may be entered in accordance with this opinion, which shall constitute the findings of fact and conclusions of law required by FRCP 52.

/s/ _____

HORACE W. GILMORE
United States District Judge

APPENDIX D

STATUTORY PROVISIONS AND REGULATION INVOLVED

1. 28 U.S.C. 1331 provides:

Federal question

The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws, or treaties of the United States.

2. 28 U.S.C. 1361 provides:

Action to compel an officer of the United States to perform his duty

The district courts shall have original jurisdiction of any action in the nature of mandamus to compel an officer or employee of the United States or any agency thereof to perform a duty owed to the plaintiff.

3. Section 205(h) of the Social Security Act, 42 U.S.C. 405(h), provides:

(h) Finality of Secretary's decision

The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under sections 1331 or 1346 of title 28 to recover on any claim arising under this subchapter.

4. Section 1802 of the Social Security Act, 42 U.S.C. 1395a, provides:

Free choice by patient guaranteed

Any individual entitled to insurance benefits under this subchapter may obtain health services from any institution, agency, or person qualified to participate under this subchapter if such institution, agency, or person undertakes to provide him such services.

5. Section 1842(b)(3), of the Social Security Act, 42 U.S.C. 1395u(b)(3), provides:

Use of carriers for administration of benefits

* * * * *

(b) Applicability of competitive bidding provisions; findings as to financial responsibility, etc., of carrier; contractual duties imposed by contract

* * * * *

Each contract shall provide that the carrier—

* * * * *

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable * * *.

* * * * *

In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services. * * *

6. Section 1869(a) and (b) of the Social Security Act, 42 U.S.C. 1395ff(a) and (b), provides:

Determinations of Secretary

(a) Entitlement to and amount of benefits

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Appeal by individuals

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to—

(A) whether he meets the conditions of section 426 or section 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or subsection 1819, or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

7. 42 C.F.R. 405.504(b) provides:

> *Variation in range of prevailing charges.* The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials in the level of charges between different kinds of practice or service could, in some localities, lead to the development of more than one range of prevailing charges for application by the carrier in its determinations of reasonable charges. Carrier decisions in this respect should be responsive to the existing patterns of charges by physicians and other persons who render covered services, and should establish differentials in the levels of charges between different kinds of practice or service only where in accord with such patterns.

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NO.

In the Supreme Court of the United States

October Term, 1984

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
PETITIONERS

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.,
RESPONDENTS

BRIEF IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI TO THE U.S. COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTION PRESENTED

Did the Court of Appeals correctly conclude that 42 U.S.C. § 1395ff and 42 U.S.C. § 405(h) did not deprive Respondents of a federal judicial forum for redress of their substantial statutory and constitutional claims.

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STATUTORY PROVISIONS AND REGULATIONS INVOLVED

28 U.S.C. §§ 1331 and 1361; 42 U.S.C. §§ 405(g), 405(h), 1395a, 1395ff, 1395u(b)(3), 1395u(b)(3)(C); and 42 C.F.R. 405.504(b). These authorities are reproduced either in the body of this Brief or in the Appendix to the Petition previously filed in this matter.

STATEMENT

1. Background

The substantive merits of this case involve a challenge to a regulation promulgated by the Secretary of Health and Human Services (Secretary) which permitted differential treatment being accorded to certain allopathic (M.D.) family physicians (and their patients) versus all other allopathic physicians (and their patients) under the Medicare Program. The differential treatment alleged by Respondents and found by both the trial court and court of appeals was implemented through the creation and maintenance of separate fee screens which placed allopathic family physicians in the same fee screen as podiatrists, chiropractors and dentists while allopathic physicians of different specialities were placed in another separate specialty fee screen.

Petitioners mischaracterize the present case from the first sentence of the Statement of their Petition. The question presented in this case is not whether the court of appeals erred in finding that 42 U.S.C. § 405(h) and 42 U.S.C. § 1395ff did not preclude federal court jurisdiction for a Medicare "amount of benefit" case. Rather the question is whether the lower court was correct in concluding that these statutory provisions cannot be interpreted to erect such a jurisdictional bar as to preclude Respondents from any forum — administrative or judicial — for the redress of their statutory and constitutional claims.

2. The Medicare Act

Petitioners' general description of the Medicare Program is sufficient and will not be repeated here in detail, except for those provisions that relate directly to the present case or those provisions not discussed by Petitioners.

Under the general scheme of the Medicare Program, the Secretary is authorized to enter into contracts with private insurance companies in order to administer Part B of the Medicare Program. 42 U.S.C. (& Supp. V) 1395u. Part B of

the Medicare Program concerns services provided by physicians. In contrast, Part A of the Medicare Program, 42 U.S.C. (& Supp. V) 1395c, et seq.), provides coverage for the reasonable cost of hospital and other institutional care. The distinction between Parts A and B of Medicare are germane to the present appeal only to the extent that it serves as a point of contrast for both past precedents and the review mechanisms permitted under each Part.

Under Part A, determinations of both "entitlement to benefits" and "amount of benefits" are made by the Secretary. 42 U.S.C. § 1395ff(a)[1] Under Part B only the determination of "entitlement to benefits" is made by the Secretary. ibid. Under Part A, an individual dissatisfied with either an eligiblity or amount of benefits determination is entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision pursuant to 42 U.S.C. 405(g). See 42 U.S.C. § 1395ff(b)[2] Under Part B, and pur-

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[1] This statute states as follows:

The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

[2] This statute states as follows:

(1) Any individual dissatisfied with any determination under subsection (a) of this section as to —

(A) whether he meets the conditions of section 426 or section 426a of this title, or
(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title, or subsection 1819, or
(C) the amount of benefits under part A (including a determination where such amount is determined to be zero) shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

suant to § 1395ff(b), only an individual dissatisfied with entitlement determinations is afforded a hearing by the Secretary and judicial review of the Secretary's final decision.

The hearing rights of individuals dissatisfied with an "amount of benefits" determination under Part B of the Act are treated separately pursuant to another provision of the Medicare Act. Specificially, § 1395u(b)(3)(C) provides that an individual will be granted an opportunity for a "fair hearing by the carrier" in cases of controversy over $100.00 with regard to services furnished or not acted upon with reasonable promptness.[3]

The other relevant statutory provision, 42 U.S.C. § 405(h), is a general statutory provision applicable to the Medicare Act by reference through 42 U.S.C. § 1395ii, which makes § 405(h) applicable to the Medicare Act to the same extent it is applicable to Title II of the Social Security Act. Section 405(h) generally indicates that the findings of the Secretary, following a hearing, are binding and no further review (judicial or otherwise) is permissible unless otherwise provided. Under the general provisions of the Social Security Act, a hearing by the Secretary (and judicial review thereafter) is accorded by 42 U.S.C. § 405(g). However, 42 U.S.C. § 1395ii fails to make § 405(g) applicable to the Medicare Act.

In addition to defining the type of hearing (conducted by the Secretary or conducted by the carrier) and discussing

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[3] This statute states as follows:

> (3) Each such contract shall provide that the carrier —
>
> * * *
>
> (C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

appellate remedies, there are other regulatory and administrative provisions which concern themselves with the fair hearing procedure that must be utilized by a carrier in cases where a request for payment is denied or when the amount of such payment is in controversy. The fair hearing conducted by the carrier is defined by regulations promulgated by the Secretary and certain provisions of the "Carrier's Manual."[4] The types of challenges that may be heard by the carrier are carefully delineated by regulation. 42 C.F.R. 405.801. The regulations provide for a hearing when a party is dissatisfied with a determination denying a request for payment, the amount of payment or where the request for payment is not being acted upon with reasonable promptness. A party is then given a right to a "fair hearing" (42 C.F.R. 405.820) conducted by a hearing officer designated by the carrier. (42 C.F.R. 405.823). The jurisdiction of the hearing officer is carefully circumscribed by regulation as follows:

> The hearing officer in exercising the authority to conduct a hearing on this Section 1842(b)(3)(c) of the Act is to comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as with policy statements, instructions and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carrier. 42 C.F.R. 405.860.

The restrictions opposed upon the hearing officer's jurisdiction are made even more explicit by the Carrier's Manual, the compilation of guidelines a hearing officer is required by the above regulation to follow. Section 12016 of the Manual states:

> Authority — the HO occupies a significant position in the administrative appeals process affording dissatisfied

[4] The Carrier's Manual was compiled by the Health Care Financing Administration. Its declared purpose is to serve as "practical operating instructions needed by the contractors responsible for the administration of the supplementary and medical insurance program — Part B Medicare. (forward to Carrier's Manual).

individuals with hearing rights as provided in Section 1842(b)(3)(C) of the Act. Authority of the HO is limited to the extent that he must comply with all provisions of Title XVIII of the Act and regulations issued thereunder, as well as with HCFA rulings, general instructions, and other guides issued by HCFA with the Medicare Bureau. *The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program.* (Emphasis added)

3. Proceedings

Respondents commenced this action on the 8th day of October, 1976. Respondents alleged the differential treatment of family physicians, compared to all other types of physicians in the State of Michigan, violated substantive due process requirements of the Fifth Amendment to the United States Constitution and the Medicare Act, specifically 42 U.S.C. 1395a (which guarantees a free choice of physicians by patients under the Medicare Program) and 42 U.S.C. § 1395u(b)(3) which requires that prevailing fee limitations be based upon "similar services"). No monetary relief was requested, but Respondents did request a finding that the maintenance of separate fee screens by Petitioners in administering the Medicare Program violated the Medicare statute and the Fifth Amendment. Respondents requested that the court enjoin Petitioners from treating family physicians differently from other physicians for purposes of the Medicare Program.

Respondents' statutory claim based upon 42 U.S.C. § 1395u(b)(3)[5] asserted that, contrary to the Medicare Act's

[5] 42 U.S.C. § 1395u(b)(3) states as follows:

"In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary

(Footnote continued on next page.)

mandate that "similar service" be the basis for determining reasonable charge, the Secretary had promulgated a regulation which authorized the carrier to segregate and group physicians on the basis of specialty practice for the purpose of developing reimbursement screens used for all types of procedures, including primary care procedures, thereby according different payment for similar service. See 42 C.F.R. 405.504(b).[6]

Prior to commencing suit, and in October, 1974, Respondents requested a hearing with the Carrier to provide the individual Respondents with an opportunity to demonstrate that Respondent-physician's training and experience were such as to warrant equal payment for primary care procedures. In December, 1974, the Carrier responded to the request indicating that Respondents could utilize a peer review procedure. In March, 1975, the Carrier further clarified the scope of the hearing by indicating that an adjudication as to the reasonableness of the specialty diffe-

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(Footnote continued from previous page.)

charges for similar services generally made by the physician or other person furnishing such service, as well as the prevailing charge in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or request for payment made under this Part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) a prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover seventy-five (75%) percent of the customary charges made for similar services in the same locality during the last preceding calendar year . . ."

[6] This regulation provides:

"The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials and the level of charges between different kinds of practice or service could, in some localities, lead to development of more than one range of prevailing charges for application by the carrier in its determination of reasonable charges. Carrier decisions in this respect shall be responsive to the existing patterns of charges by physicians and other persons who render covered services and should establish differentials in the level of charges between different kinds of practice or service only where in accord with such patterns."

rential could *not* be involved and the Carrier would accept no adjudication which eliminated such a differential. Additionally, Respondent-patient, without counsel, protested the prevailing fee determination as to services performed by her treating physician and was notified by the Carrier that she was without recourse and nothing could be done.

Prior to trial, the Secretary moved to dismiss Respondents' Complaint for lack of jurisdiction as to the statutory and regulatory claim and as to the constitutional claim on the basis that the constitutional claim was insubstantial. In December, 1977, the Secretary's motion was denied by the district court in a memorandum opinion which noted:

> I am influenced by the improbability that Congress would intentionally authorize an administrative agency to delegate to a private contractor the power to violate the Constitution of the United States in the name of the United States without recourse.

Following trial on the merits and with regard to the differential screens permitted by 42 C.F.R. 405.504(b), the district court held that the Carrier had neither developed a procedure to determine what types of professional services were similar nor carried out a statistical study to determine actual charging patterns for different types of providers. Instead, the carrier had established three "screens" in order to make reasonable charge calculations. The Carrier implemented this differential screen procedure in such a fashion as to group certain Respondent-family practice physicians in the same pool as dental surgeons, chiropractors and podiatrists. The district court found the regulation authorizing such a classification scheme (42 C.F.R. 405.504(b)) to be plainly inconsistent with the clear mandate of the Medicare Act which "mandates the customary charges of physicians for similar services to be the test for reimbursement." 502 F. Supp. at 755.

The district court furthermore found that this classification scheme violated yet another provision of the Medicare

Act, 42 U.S.C. § 1395a, because it tended to influence a beneficiary's choice of physician and reduced that beneficiary's reimbursement solely by virtue of the choice of the type of physician to perform a particular medical service.[7]

Since the district court found the Secretary's and Carrier's actions to be a clear violation of the Medicare Act, it did not consider the constitutional arguments advanced by Respondent yet it did state that "such segregation is not rationally related to a legitimate purpose of the Medicare statute." 502 F. Supp. at 575.

It is important to note that in stating the case as developed before the district court, the Petitioner again mischaracterizes the proceedings. In footnote 1 of its Petition filed in this matter, the Petitioner indicates that the Secretary acknowledged an error before the district court in that board-eligible family physicians were classified as "non-specialists." Specifically, it was conceded before the district court that board-eligible family physicians should not have been placed in the same screen as chiropractors and podiatrists. However, Petitioners misstate the record wherein they state that the Secretary agreed that board eligible physicians would thereafter not be classified in this fashion. In fact, while conceding the error, the Petitioner declined the district court's suggestion that a voluntary remedy by way of reclassification take place. (See Appendix A)

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[7] The district court demonstrated the financial impact of this classification scheme by focusing on the effect upon respondent-patient. Respondent-patient was a Medicare recipient whose treating physician was a family physician who had been at practice for twenty-three (23) years. While being on staff at three different hospitals and while being an instructor at Michigan State University, this physician was neither board eligible nor board certified by the American Board of Family Practice. The district court noted that solely as a result of selecting this physician (a choice protected pursuant to 42 U.S.C. § 1395a) respondent-patient was in fact paying more for her physician visits and treatments although paying the same premium as another recipient who may have chosen a physician defined by the Petitioner as a "specialist."

By way of remedy, the district court issued a mandatory injunction directing the Petitioners to provide a single screen for all physicians separate and apart from a screen for chiropractors, podiatrists and dentists.

The court of appeals affirmed the decision of the district court, both in terms of subject matter jurisdiction and the substantive merits of the lawsuit. However, that court determined that the remedy adopted by the district court went too far. The court of appeals remanded the case to the Secretary for reconsideration of the reimbursement plan with the proper focus of "similar service."

As to jurisdiction, the court of appeals recognized that this Court's decision in *U.S.* v *Erika*, 456 U.S. 201 (1982), held that Congress clearly and convincingly intended no judicial review of amount of benefit cases. Contrary to the impression gained from a reading of the Petition in this matter, the court of appeals did not first determine this to be an amount of benefits case and nonetheless find jurisdiction.[8] Rather, after a review of the applicable statutes and case law, the court concluded that jurisdiction did exist under the particular circumstances of this case since there would be no other forum for Respondents to press their statutory and constitutional claims and there was no "clear and convincing" showing of legislative intend to bar such jurisdiction.

As to the merits of Respondent's case, the court of appeals found that the "touchstone" of 42 U.S.C. § 1395u(b)(3) is "similar service" and that there was an obvious inconsistency between this statute and the disputed regulation. The court of appeals found the regulation "irra-

[8] In the Petitioners' zeal to convince this Court that the circuit court's opinion was erroneous, the Petitioners again mischaracterize the record. Petitioners quote at page 6 of their Petition the circuit court as stating "the eventual result of [this] suit may cause an increase in the amount of reimbursement." The actual quote from the court of appeals is that, "while the eventual result of this suit may cause an increase in the amount of reimbursement, *that does not necessarily follow*." (Emphasis added)

tional" and "invalid" 728 F. 2d at 329. Because the regulation was statutorily unsound the court did not address the constitutional issues raised by the case. See *Hagans* v *Levine*, 415 U.S. 534 (1974).

It is pertinent to appreciate that the Petition raises only the issue of subject matter jurisdiction. Both the district court and court of appeals found in favor of the Respondents on the substantive merits of this case and found, in short, that the Secretary had promulgated a regulation (42 C.F.R. 405.504(b)) which was inconsistent with the Medicare Act. Since Petitioners have failed to perfect an appeal on the substantive merits of the lawsuit, this aspect of the case is not properly before this Court and need not be decided. *Namet* v *U.S.*, 373 U.S. 179 (1963); *Ryan* v *U.S.*, 379 U.S. 61 (1964); *F.D. Rich Company, Inc.* v *U.S.*, 417 U.S. 116 (1974); *U.S.* v *ITT Continental Baking Company*, 420 U.S. 223 (1975). By failing to perfect an appeal on the substantive merits of this case, the Petitioners have failed to contest the fact that a violation of the law took place.[9] Accordingly, the Petition in this matter postures the case such that this Court is to decide whether there was jurisdiction to find the statutory violations in fact found by the district court and upheld by the court of appeals.

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[9] In a footnote Petitioners attempt to take issue with the substantive merits of this case as well. See Petition, fn. 5. However, Petitioners are obviously bound by the fact that they have chosen to appeal this case only on jurisdictional grounds. Additionally, the comments made by Petitioners are in complete contravention of the testimonial record established in this case. Simply stated, the record established that there was no meaningful difference between physicians of different specialties performing the *same* procedure.

SUMMARY OF ARGUMENT

This case presents the issue of whether an administrative branch of the government charged with enforcing a complex federal program (the Medicare Act) can first develop a system of hearings and review that differentiates and classifies types of claims and affords those claims differential hearing and appellate avenues and then contend that substantial statutory and Constitutional claims (for which no administrative review is offered) can be foreclosed from judicial review. The import of this Court's decisions in *Weinberger* v *Salfi*, 422 U.S. 749 (1975); *United States* v *Erika, Inc.*, 456 U.S. 201 (1982); *Heckler* v *Ringer*, ____ U.S. ____; 104 S. Ct. 2013 (1984); and *Schweiker* v *McClure*, 456 U.S. 188 (1982) strongly indicate that the interpretation placed upon 42 U.S.C. § 405(h) and § 1395ff by the Petitioner in untenable since it would foreclose the substantial statutory and constitutional claims presented by the Respondents.

In this case, Respondents requested an administrative review but were informed that such a review could not address the very claims which Respondents wished to pursue. The regulatory and administrative authority pertinent to this matter, in fact, stripped the administrative process of the ability to resolve the claims pressed by Respondents. The decisions of this Court have never concluded that § 405(h) or § 1395ff preclude jurisdiction over substantial statutory or constitutional claims for which no other review is accorded. Rather, this Court has in fact addressed substantial constitutional claims arising out of the Medicare Program. See *Schweiker* v *McClure, supra*. This Court's decisions in *Salfi, Erika,* and *Ringer* stand for the propositions that claimants must first pursue any available administrative remedy before asserting federal court jurisdiction and that federal court jurisdiction is precluded for "amount of benefits" cases. The present case is not properly characterized as an amount of benefit case since Respondents, as in *McClure,* made a broad statutory and constitutional claim against a federal regulation. The claims made did not ad-

dress the specific amount to be paid but rather addressed a classification scheme inconsistent with a mandate of the Medicare Act. These claims were certainly not insubstantial as the district court found a statutory violation and that court's decision was affirmed by the court of appeals. The Petition challenges the lower court only on the issue of subject matter jurisdiction.

The construction of §§ 405(h) and 1395ff advanced by Petitioners would allow Petitioners to violate the law with impunity. Indeed, in the district court Petitioners admitted a violation of the law, refused the district court's suggestion that a remedy be fashioned, but yet now insist that no forum exists for the redress of the very violation they concede. It is respectfully suggested that this Court must interpret 42 U.S.C. §§ 405(h) and 1395ff in such a fashion as to avoid such a serious constitutional issue and in a fashion which also gives meaning and effect to the various provisions of the Act.

ARGUMENT

Through the last several years, this Court has had several occasions to consider the administrative review mechanisms of the Social Security Act and the related issue of federal court jurisdiction. See *Weinberger* v *Salfi*, 422 U.S. 749 (1975); *United States* v *Erika Inc.*, 456 U.S. 201 (1982); *Heckler* v *Ringer*, _____ U.S. _____; 104 S. Ct. 2013 (1984). In addition, this Court has previously addressed, without any significant discussion of jurisdiction, a constitutional challenge to the administrative review mechanisms of Part B of the Medicare Program. *Schweiker* v *McClure*, 456 U.S. 188 (1982). The Petition filed in this matter incorrectly posits that the decision of the court of appeals in this matter is inconsistent with the collective import of these decisions and calls for the grant of a writ of certiorari. Contrary to the Petition's suggestion, a review of these decisions indicates that this Court has never interpreted or applied 42 U.S.C. § 405(h), or other provisions of the Social Security Act, as foreclosing all forums to redress substantial statutory or constitutional challenges to the Act.

In *Weinberger* v *Salfi*, *supra*, this Court faced a constitutional challenge to provisions of the Social Security Act which prohibited a wage earner's widow or stepchild from receiving insurance benefits unless the relationship to the wage earner existed nine months prior to his death. This Court carefully reviewed each of the three sentences contained within § 405(h) and first concluded that this section constitutes more than a requirement for exhaustion of administrative remedies. This Court secondly rejected any narrow reading of the language "any claim arising under . . . the Social Security Act" since the facts of *Salfi* involved Social Security benefits and provided "both the standing and substantive basis for the presentation of . . . constitutional contentions." 422 U.S. at 761.

A third element of this Court's opinion in *Weinberger* v *Salfi*, *supra*, was its distinction of the prior case of *Johnson* v *Robison*, 415 U.S. 361 (1974). This Court distinguished

§ 405(h) from a statute applicable in that case (38 U.S.C. § 211(a)) by stating that acceptance of the government's interpretation of the statute in *Robison* would have meant that no judicial consideration of a constitutional challenge could have taken place. This Court stated:

> Not only would such a restriction have been extraordinary, such that 'clear and convincing' evidence would be required before we could ascribe such intent to Congress, . . . but it would have raised a serious constitutional question of the validity of the statute so construed. 422 U.S. at 763 (citations omitted)

The court noted that the satutory scheme faced in *Salfi* was distinct from *Robison* since there was no foreclosure of important constitutional challenges. Rather, those challenges could be first channeled through the administrative process pursuant to the terms of 42 U.S.C. § 405(g) and then pursued in federal district court. This Court noted:

> In the present case, as will be discussed below, the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. Thus, the plain words of the third sentence of Section 405(h) do not preclude constitutional challenges. They simply require that they be brought under jurisdictional grants contained in the Act, and thus in conformity with the same standards which are applicable to non-constitutional claims arising under the Act . . . 422 U.S. at 762

It is clear from reviewing the decision in *Salfi* that this Court was concerned that § 405(h) not be interpreted to preclude constitutional challenges. This principle was neither ignored nor forgotten in the subsequent decisions of this Court.

In *United States* v *Erika, supra,* this Court faced a case involving Part B of the Medicare Act. The judicial action in that case was commenced following an administrative review by the carrier pursuant to 42 U.S.C. § 1395u(b)(3)(C). The substantive challenge boiled down to the carrier's de-

termination to base "reasonable charge" upon a price list utilized by the Respondent-provider. There was no constitutional claim pressed before this Court. See *U.S.* v *Erika, supra,* at fn. 5.

This Court's opinion in *Erika* dealt mainly with the correct interpretation to be given to § 405(h) in conjunction with § 1395ff. Because § 1395ff failed to provide for a hearing by the Secretary (or judicial review thereafter) for "amount of benefits" cases under Part B, and because the legislative history revealed an intent to distinguish between "amount of benefits" cases under Part B and other types of challenges for purposes of judicial review, this Court determined that the administrative hearing afforded in *Erika* was appropriate and no further judicial review was permissible.

Contemporaneously with issuing the *Erika* opinion, this Court also handed down its opinion in *Schweiker* v *McClure, supra.* The *McClure* case once again dealt with Part B of the Medicare Program but was distinct from *Erika* in that the challenge in that case was directed at the hearing procedure mandated by 42 U.S.C. § 1395u(b)(3)(C) and implemented through regulation. Once again, the claimants in *McClure* had gone through an administrative hearing and, thereafter, filed suit in district court contending that the hearing which they were afforded was constitutionally infirm. Relevant to this discussion, this Court did not consider the basic jurisdictional issue but went on to substantively address the constitutional claims and ruled that the carrier hearing, as mandated by the statute and implemented through regulations, passed constitutional muster. *McClure* was notably distinct from *Erika* since the issues brought before the federal district court were not "amount of benefits" issues but were rather broad constitutional challenges to the overall administrative review process adopted by the Secretary (through promulgation of several regulations) and acted upon by the carrier.

Just recently this Court issued its opinion in *Heckler* v *Ringer, supra,* which again focused upon judicial review of

a Medicare case, although this Court's decision was limited, in the main, to a discussion of judicial review of a Part A claim. *Heckler* v *Ringer, supra* at fn. 4. In *Ringer,* Respondents initially challenged an instruction and ruling by the Secretary which had the purpose of limiting Medicare reimbursement for a particular surgical procedure. This Court distinguished between the Respondents since three of the Respondents had had the surgery performed prior to the Secretary's limiting instructions whereas the fourth Respondent (Ringer) had yet to undergo the surgery claiming that he could not afford to do so if it was not a covered benefit. Before the administrative review available under Part A had been completed, a challenge was made to the Secretary's limiting instruction through filing suit in federal district court. The precise issue faced by this Court was whether the Respondent could pursue their case in federal district court prior to having their claims first channeled into the administrative process available under Part A and, in the case of Respondent Ringer, before the surgery was actually performed.

This Court held that § 405(h) barred federal court jurisdiction over the Respondents' claims since Respondents had failed to exhaust their administrative remedies provided under § 405(g) in the confines of their Part A claims. As to Respondent Ringer, this Court declined the invitation not to enforce the provisions of § 405(h) to a Medicare claimant who had yet to undertake the surgery since to do otherwise would have opened the door and allowed a by-pass of the administrative remedy provided by the Act. This Court noted:

> If we allow claimants in Ringer's position to challenge in federal court the Secretary's determination . . . that BCBR surgery is not a covered service, we would be inviting them to by-pass the exhaustion requirements of the Medicare Act by simply bringing delcaratory judgment actions in federal court before they undergo the medical procedure in question. 104 S. Ct. at 2025.

From these precedents, the Petitioners weave their argument for requesting relief from this Court. From the *Salfi* opinion they take the principle that § 405(h) applies to any action "arising under" the Medicare Act. From the *Erika* opinion they take the principle that all "amount of benefit" cases are without recourse to judicial review. From the *Ringer* opinion they take the principle that the administrative channels and judicial review established by § 405(g) and §405(h) cannot be circumvented by a premature district court action by clothing benefits cases in procedural dress. Petitioners then characterize the present case as an "amount of benefits" case which "arises under" the Medicare Act and is hence without federal court jurisdiction pursuant to § 405(h). Despite the Petitioners' best efforts, however, the precedent of these cases cannot collectively establish the principle that judicial review is foreclosed in a Part B Medicare case in which a statutory and constitutional challenge is made and for which there is no administrative process to address these challenges. Indeed, the decisions of this Court stand for quite the opposite.

An important element of this Court's analysis in the *Salfi* case was the recognition that the challenges made by the claimants could be properly addressed and channeled through the administrative process provided by § 405(g). In *Erika* judicial review was foreclosed but only over certain types of challenges, namely amount of benefits cases, since there was clear legislative intent to free the judicial process of these small benefit cases. This Court recognized that the constitutional claims presented were neither pressed before this Court nor of a substantial nature. *Erika* was consistent with Salfi regarding foreclosure of statutory or constitutional claims since the claims raised in *Erika* were concerned solely with the determination of amount of benefit and expressly did not concern substantial statutory or constitutional claims. A judicial forum was not available since such a forum was not expressly provided by statute *and* legislative history revealed a clear intent to bar judicial review of the very type of claim being pressed. In *Ringer*

the claimants had recourse to administrative review (and judicial review thereafter) under § 1395ff(b) and § 405(g) but simply failed to pursue it.

Perhaps the best indication that this Court's opinions do not foreclose statutory or constitutional claims under the Medicare Act is this Court's opinion in *McClure*. Decided the same day as *Erika*, this Court readily considered the constitutional challenges presented without being concerned with the initial jurisdictional question.

The present case was initiated as a statutory and constitutional challenge to a regulation promulgated by the Secretary. Respondents were not seeking any specific payment level concerning a particular medical service or procedure (contrast both *Erika* and *Ringer*) but were claiming that the Secretary and Carrier had gone beyond the basic mandate of both the Medicare Act and the United States Constitution. Like *McClure*, Respondents made a broad challenge to the promulgation of a regulation. That challenge was not based upon a question of medical necessity or proper *application* of the Medicare regulations to a particular claim for payment. Such claims could have been pursued through the administrative hearing mechanism mandated by 42 U.S.C. § 1395u(b)(3)(C) and established by regulation.

Unlike the claimants in *Erika* or *Ringer*, Respondents did not seek payment of a necessarily higher amount or payment for a procedure determined to be unnecessary or otherwise nonreimbursable by the Secretary. Respondents' claims were based upon the premise that whatever payment was to be made should be made according to "similar service" and the regulation in issue violated this statutory premise. Respondents objected not to the application of the classification scheme permitted by the regulation but the classification scheme itself. Such a determination is not concerned with "amount of benefits" as discussed and defined in *Erika*.

Respondents' statutory and constitutional claims had to be pursued in the statutory and regulatory matrix that had been established for the Medicare Program. The Medicare Act, pursuant to § 1395ff(b) does not discuss either administrative review or judicial review of such challenges under Part B. Similarly, while 42 U.S.C. § 1395u(b)(3)(C) calls for a hearing by the carrier, the Secretary specifically removed from the carrier's power the capacity to address the very type of challenge being pursued by Respondents. It will be recalled that the applicable regulation states:

> The hearing officer exercising the authority to conduct a hearing on this § 1842(b)(3)(C) of the Act is to comply with all of the provisions of Title XVIII of the Act and the regulations issued thereunder, as well as with policy statements, instructions, and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carrier. 42 C.F.R. 405.860.

In addition, the hearing officer assigned by the carrier is specifically instructed by the Secretary not to decide or comment upon the legality or constitutionality of any regulation relevant to the Medicare Program. As stated previously, the Carrier's Manual specifically states:

> The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program. Carrier's Manual, § 12016.

Although faced with this foreclosure of the very claims they wish to press, Respondents, nonetheless, requested an administrative hearing making very clear the type of claim being pursued. As previously mentioned, Respondents' inquiries were answered in such a fashion to make abundantly

clear that the carrier hearing afforded by § 1395u(b)(3)(C) simply did not have the ability to remedy the specific injustice claimed by Respondents. Respondents belief that it is ironic that the regulatory scheme fashioned by the Petitioner and the Petitioner's specific statements to Respondents demonstrated the fact that the administrative review available could not have addressed the Respondents' challenges, yet Petitioner now attempts to pigeonhole Respondents' challenges as "amount of benefits" claims — which of course could have been administratively addressed.

There is yet another more practical reason why characterization of the present case as an amount of benefits case is inaccurate. Respondent-Academy is a state chapter of a national organization known as the American Academy of Family Physicians. This organization consists of approximately 1,500 licensed allopathic physicans who have agreed to meet the standards of the national organization. The American Board of Family Practice was established in 1969 as a specialty practice board. Because certification as a family physician specialist has existed basically from the inception of the differential screens in dispute in this matter, there were board certified family physicians who were placed in the specialty screen. Therefore, the relief sought by Respondents stood to potentially decrease the amount of reimbursement of certain family physician members who had been previously placed in the specialty screen utilized by the Carrier in this case. Accordingly, it is inaccurate to characterize the Respondents' case as simply seeking to increase the "amount of benefits" they may receive under the Medicare Program. Respondents' claims were clearly delineated to address the classification scheme and differential treatment being accorded and the illegal and unconstitutional aspects of the disputed regulation.

It is a matter of long precedent with this Court that the foreclosure of all forums to address substantial constitutional claims itself raises "serious constitutional questions." See *Johnson* v *Robison, supra,* see *Bob Jones University* v

Simon, 416 U.S. 725 (1974). This Court has called it a "cardinal principle" that statutory provisions are to be interpreted so as to avoid this very sort of basic constitutional question. See *United States* v *Thirty-Seven Photographs*, 402 U.S. 363 (1971); *Johnson* v *Robison, supra; Crowell* v *Benson*, 285 U.S. 22 (1932).

This precedent certainly has not been ignored by this Court in addressing the proper interpretation of § 405(h). Indeed, this Court in *Salfi* recognized this precedent and reviewed the other provisions of the Social Security Act and concluded that " . . . the plain words of the third sentence of § 405(h) do not preclude constitutional challenges." 422 U.S. at 762. Likewise, under the facts present before this Court in *Ringer*, the "procedural" claims being pressed by the claimants could still have been pursued if only those claimants would have first made use of the administrative remedy available to them pursuant to § 1395ff(b) and § 405(g). Respondents are not suggesting that the interpretation of § 405(h) shift from the previous decisions of this Court. The simple fact is this provision has never been interpreted by this Court as foreclosing all forums for the redress of substantial statutory and constitutional challenges to the Act. To do so in this case would raise a constitutional question of the first dimension. Justice Brandeis recognized this principle many years ago with the following words:

> When dealing with constitutional rights . . . there must be the opportunity of presenting in an appropriate proceeding at some time, to some court, every question of law raised, whatever the nature of the right invoked or the status of him who claims it. *St. Joseph Stockyard Co.* v *U.S.* 298 U.S. 38 (1935) (Brandeis, J., concurring)

In interpreting and applying § 405(h) in the context of medicare cases, federal courts have universally declined to interpret § 405(h) so as to preclude all forums for the address of substantial constitutional questions. See *Hospital San Jorge, Inc.* v *United States*, 598 F. 2d 684 (1st Cir.

1979); *Dr. John T. McDonald Foundation, Inc.* v *Califano*, 571 F. 2d 328 (5th Cir. 1978), cert. denied 439 U.S. 893 (1978); *Trinity Memorial Hospital of Cudahy, Inc.* v *Associated Hospital Service, Inc.*, 570 F. 2d 660 (7th Cir. 1977); *South Windsor Convalescent Home, Inc.* v *Matthews*, 541 F. 2d 910 (2nd Cir. 1976); *St. Louis University* v *Blue Cross Hospital Service*, 537 F. 2d 283 (8th Cir. 1976), cert. denied sub nom. *Faith Hospital Association* v *Blue Cross Hospital Service, Inc.*, 429 U.S. 977 (1976); *Chelsea Community Hospital, SNF* v *Michigan Blue Cross Association*, 630 F. 2d 1131 (6th Cir. 1980); *United States* v *Aquavella*, 615 F. 2d 12 (2nd Cir. 1979); *Starnes* v *Schweiker*, 715 F. 2d 134 (4th Cir. 1983), vacated and remanded sub nom. *Heckler* v *Ringer, supra; National Association of Home Health Agencies* v *Schweiker*, 690 F. 2d 932 (D.C. Cir. 1982) cert. denied, 103 S. Ct. 1193 (1983). It would certainly be inappropriate to claim that there is a "conflict" among the inferior federal courts on this issue as a basis for granting a writ of certiorari. See Supreme Court Rule 17.1(a).

To conclude that § 405(h) may serve to foreclose substantial statutory and constitutional claims becomes that much more untenable when the entire statutory and regulatory scheme is considered. Even in cases where no key constitutional claim is made, this Court has held that judicial review of an agency's final determination will not be foreclosed unless there is "clear and convincing evidence" of a legislative intent to so limit or restrict a judicial forum. *Abbott Laboratories* v *Gardner*, 387 U.S. 136 (1967). A recent opinion of this Court suggests that this presumption of judicial review can, under certain circumstances, be overcome where the intent to preclude judicial review is "fairly discernible in the statutory scheme." *Block* v *Community Nutrition Institute*, ____ U.S. ____ ; 104 S. Ct. 2450 (1984). See also, *Data Processing Services* v *Camp*, 397 U.S. 150 (1970).

A review of the statutory and regulatory scheme here certainly does not reveal a fairly discernible intent to pre-

clude judicial review for a Medicare Part B case which raises substantial statutory and constitutional issues. As previously discussed, the impact of a § 1395ff in conjunction with § 1395u(b)(3)(C) and § 405(h) evidences a legislative intent to channel small amount of benefit cases through an administrative hearing process conducted not by the Secretary but by the carrier.

Pursuant to regulatory and administrative authority, the carrier hearing process, as required by § 1395u(b)(3)(C), is specifically limited and cannot address a statutory or constitutional challenge. What is discernible in this scheme is only the foreclosure of judicial review of those issues for which a meaningful administrative hearing is available. The legislative history discussed in *Erika* obviously cannot be read as evidencing an intent to foreclose judicial review for claims of a type other than the amount of benefit claims discussed in that history.

A basic tennet running through the cases which have discussed § 405(h) is that claimants should make use of any administrative avenues of relief before instituting suit in the federal courts. See *Weinberger* v *Salfi, supra;* and *Heckler* v *Ringer, supra*. However, where there is no meaningful administrative review (as in this case where the unavailability of that administrative review is apparent both from the applicable regulatory and administrative authority and through response to a specific request for hearing) an intent to foreclose all judicial review is certainly not discernible from the statutory scheme.

Petitioner, citing this Court's order of remand in *Heckler* v *Starnes*, ____ U.S. ____; 104 S. Ct. 2673 (1984) asks this Court to similarly remand the current case to the Sixth Circuit Court of Appeals for reconsideration in light of this Court's Opinion in *Ringer*. A review of the facts of the court of appeals' *Starnes* opinion indicates that there was a great similarity to the facts present in the *Ringer* opinion. However, further review indicates that a remand would not be appropriate in the case at bar.

In *Starnes*, the court of appeals was faced with a case in which both Medicare beneficiaries and providers of care challenged certain determinations made by the Secretary which served to limit the amount of reimbursement received for the rendering of a particular procedure — computerized tomography. The Secretary had established a national ceiling for payment of this procedure through the issuance of several letters and memoranda. Like *Ringer*, the claimants alleged that the actions of the Secretary were "procedurally" incorrect and made a constitutional challenge as well. Before reaching this Court, court of appeals dismissed the constitutional claim terming said claim "frivolous." See *Starnes* v *Schweiker, supra* at fn. 4.

The court of appeals' decision in *Starnes* is inconsistent with this Court's opinion in *Ringer* since both cases involved claimants seeking reimbursement for a particular procedure which the Secretary, through an allegedly inappropriate procedural means, had limited or denied. In *Ringer*, this Court took specific note that the bottom line of the claimant's challenge was payment for a particular medical service. The same characterization has merit with regard to the *Starnes* case.

It would be erroneous to conclude that the case at bar present a similar issue as that faced by *Ringer* and *Starnes*. This is not a case which labels an amount of benefits determination as a procedural error or anything of the type. As previously discussed, Respondents' dispute was with a classification scheme, not application of a regulation or particular decision on a claim for payment. The Court of Appeals for Sixth Circuit recognized this distinction as can be demonstrated through another Medicare Part B case previously decided by that Court.

In *Herzog* v *Secretary*, 682 F. 2d 121 (6th Cir., 1982) the Court of Appeals for the Sixth Circuit faced a case in which the claimants disputed the fact that chelation therapy was held by the Secretary to be non-reimbursable. The claimants sought and were afforded an administrative review of

this adverse decision. They consequently filed suit in the federal district court but made no constitutional challenge to the adverse determination until an adverse district court opinion led to court of appeals' review. The court of appeals, relying extensively on this Court's opinion in *Erika*, ruled that federal court jurisdiction did not exist to hear the claimants amount of benefits case. The court of appeals specifically noted that the Plaintiffs had failed to allege any constitutional claim in their complaint.

Under these circumstances it is clear that the Court of Appeals for Sixth Circuit is mindful of this Court's *Erika* opinion and that the case at bar is decidedly distinct from the facts presented in the *Ringer* and *Starnes* cases. Accordingly, it would be inappropriate to remand this matter back to the court of appeals for further consideration in light of this Court's *Ringer* opinion.

CONCLUSION

The Petition for Writ of Certiorari should be denied. If this Court decides to grant the Petition, it is respectfully submitted, for the reasons previously discussed, that a remand to the Court of Appeals for the Sixth Circuit is inappropriate and that this Court simply docket this matter for decision on the merits.

Respectfully submitted,
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By: ALAN G. GILCHRIST
Counsel of Record

By: DAN ELLIS CHAMPNEY

APPENDIX

(63)

TRIAL TRANSCRIPT

* * * trial.

Q. Have you ever heard of any rationale with then HHS as to why the carrier in Michigan has treated board eligible family physicians different from other types of board eligible physicians?

A. I have never seen anything that fully explains that. I have been under the impression at one time or another that there were differences in the various board rules dealing with the requirements of becoming board certified that the carrier was concerned about, but I do not recall what they are specifically.

MS. MAYES: Your Honor, if I might just raise a question. We have indicated at the beginning of this case that we believe that we were incorrect in defining family practioners, that is, those who were board eligible, as not being specialists, and that therefore we conceded that fact before this trial ever began. That was an incorrect application of that board eligible definition, so that board eligible family practioners should be defined as specialists by the carrier in the State of Michigan.

THE COURT: And should be put in the screen?

MS. MAYES: That question is what is left open, but the definition of what we called them was (64) incorrect.

THE COURT: All right. Go ahead.

BY MR. GILCHRIST:

Q. Would it be a fair statement that the rationale that you have heard for treating board eligible family physicians differently from other board eligible physicians has never been related to any charging patterns?

A. I am not sure I understand your question. I am sorry.

Q. Well, you said you talked about—there was something about qualifications of speciality boards as one of the rationale.

A. It had been my understanding that there was a difference in requirements for board certification, for remaining board eligible rather for physicians in family practice as opposed to physicians in other speciality fields. Now that may or may not be so. I don't know. I have no personal knowledge of that.

Q. Okay, but at the time you understood that to be the rationale. Did you treat that as the basis on which to put the board eligible FP into a separate screen?

A. Well, that determines on what the charge pattern really is.

Q. That is what I am trying to figure out. Did you ever hear the rationale that there was a difference in charge patterns between a board eligible family physician * * *